August 3, 2023

Carole Johnson, MA
Administrator
Health Resources and Services Administration
5600 Fishers Lane
Rockville, MD 20852

Dear Administrator Johnson:

Thank you for the work of the Health Resources and Services Administration (HRSA) to begin the implementation of the Pediatric Subspecialty Loan Repayment Program. This important program was created to address the serious shortages of pediatric medical subspecialists, pediatric surgical specialists, and pediatric mental health providers across the United States, which directly impact access to equitable care for children, especially those with serious, chronic or complex health care needs. As HRSA works to process applications and make awards, we wish to offer recommendations to ensure that the program benefits the pediatric subspecialists it is intended to support.

As you know, the first application cycle for this program opened in June 2023 and recently closed on July 25. During the application window, a large number of pediatric subspecialists, children's hospitals and departments of pediatrics shared their experiences navigating the program requirements and application experience and described numerous challenges with the process, which we describe below.

We understand that this year's program was built upon HRSA's existing platforms for offering loan repayment to primary care providers. However, those existing programs tend to be geared toward care delivered in community health centers and do not reflect the substantial differences between adult and pediatric care overall and between primary and specialty care more specifically. Indeed, the significant challenges that pediatric providers and facilities faced during the application process are due, in large part, to the fact that those existing platforms do not reflect how pediatric subspecialty care is provided. Therefore, we offer our assistance to help HRSA address some of the differences between primary and subspecialty care during this current cycle's application review process, and highlight additional issues that may necessitate different policy approaches moving forward.

In particular, the clinical service hours and the eligibility criteria were key obstacles during this application cycle and will continue to impede participation in the program if they are not made consistent with actual pediatric subspecialty practice. In addition to addressing the clinical service hours requirement during this year's review process and in subsequent years, we urge HRSA to clarify eligible subspecialties and eligible service sites, and revise how HRSA evaluates applications for school-based providers.

CLINICAL SERVICE HOURS REQUIREMENT

A significant barrier pediatric subspecialists encountered in applying for the program is the clinical service hours requirement. HRSA's physician clinical service hours requirement, which is based on requirements under the National Health Service Corps, is inconsistent with how pediatric subspecialty care is practiced and how the future pediatric subspecialty workforce is trained. While we understand HRSA's interpretation of the statute is intended to maximize the clinical time of awardees, we are concerned that the service hours requirement will result in most pediatric subspecialists being ineligible,

given the norms of pediatric subspecialty practice. It may also result in fellows, who must fulfill research responsibilities during fellowship, and particular subspecialties being virtually completely excluded from the program. As a result, some pediatricians could be disincentivized from entering certain subspecialities, undermining the program's intent to improve access to care for children and bolster the pediatric subspecialty workforce pipeline.

The program guidance specifies that, in order to be eligible, pediatric medical subspecialists and pediatric surgical specialists must work at least 40 hours per week for a minimum of 45 weeks per year. Of these 40 hours, a minimum of 36 hours (or 90%) must be providing clinical care and only 4 hours may be used for other activities such as administrative work, quality improvement, research, or teaching.

While service hour requirements like this may be reasonable for some primary care providers working in community settings, they are generally not consistent with how pediatric subspecialty care is practiced. Therefore, this will result in the majority of pediatric medical subspecialists and pediatric surgical specialists being unable to demonstrate eligibility for the program. According to data from the American Board of Pediatrics (ABP), while the average general pediatrician spends 78% of their time on clinical care, the average pediatric subspecialist only spends 64% of their time on clinical care.[1] Pediatric subspecialists spend less time on direct clinical care because they are engaged in other critically important clinically-relevant work, including research, teaching, and quality improvement. They also engage in peer-to-peer consultation, including e-consults, telephone consults with primary care providers, inpatient consultant work, and case conferences.

Academic and Hospital-Based Clinical Service Hours

Compared to primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists are much more likely to work in children's hospitals and other academic and hospital-based settings. Compared to primary care, working in these settings comes with responsibilities in addition to direct patient care. According to data from the ABP, 60% of pediatric subspecialists work in academic or hospital-based settings, including children's hospitals, whereas only 22% of primary care pediatricians work in these settings.[2] There are very good reasons why pediatric subspecialty care often needs to be conducted in academic and hospital-based settings. These are the settings that have the resources and technologies needed to care for children with serious, chronic or complex medical needs, such as advanced diagnostics (e.g., MRI, CT), inpatient facilities, surgical facilities, and the co-location of other types of specialty providers needed to support their care. The care system for children with medical complexity is due to the fundamental difference between adult and pediatric specialty care: pediatric medical complexity, such as congenital heart disease and pediatric cancer, is relatively rare. Therefore, much of their care must be regionalized in children's hospitals in order to achieve sufficient patient volume and quality of care.

---

[1] American Board of Pediatrics. MOC Enrollment Survey 2018-2022. Question: What proportion of your total professional time is spent performing each of the following tasks? Adapted from https://www.abp.org/content/results-continuing-certification-moc-enrollment-surveys-2018-and-2019. Data based on pediatric subspecialties certified by the ABP.

[2] ABP MOC Enrollment Survey 2018-2022. Question: primary work setting. Average of responses: (1) medical school or parent university, (2) non-government hospital/clinic, (3) city/county/state/government hospital/clinic, and (4) US government hospital/clinic.

Pediatric subspecialists also spend a significantly higher proportion of their time teaching and conducting research compared with primary care pediatricians. Data from the ABP show that pediatric subspecialists on average spend 18% of their time on research and providing medical education, compared with only 7% for primary care pediatricians. Given the significant shortages of pediatric subspecialists across the country, it is important that subspecialists are able to commit some of their time to helping build the next generation of pediatric subspecialists. Furthermore, given that children are generally underrepresented in medical research and often do not benefit from research conducted in adults, the conduct of pediatric-focused research greatly benefits children by improving the base of evidence upon which children with specialized needs are cared for. Pediatric subspecialty care in academic settings also provides the infrastructure for pediatric research to be conducted.

In addition, it is common for pediatric subspecialists to spend intensive periods of time "on service" working significant clinical hours followed by stretches of time working predominantly on other non-clinical activities. For instance, a subspecialist could spend two weeks "on service" providing around 90 hours per week of clinical time followed by three weeks conducting non-clinical work, such as research. In fact, if those 180 hours of clinical time were averaged over the five weeks, that clinician would meet the current program guidance's 36-hour clinical service requirement. Further, during the weeks not "on service," subspecialists are often still providing clinical care within the hospital, albeit not face-to-face clinical care. Rather, they are responding to patient issues via telemedicine or through patient portals or coordinating care with generalist pediatricians. While these clinical service arrangements are rare in primary care, they are common in subspecialty practice, and very common in particular subspecialties such as pediatric critical care, hospital medicine, or neonatology. **We urge HRSA to adopt a more flexible approach to assessing clinical service eligibility in its review of this year's applicants that is more reflective of the realities of pediatric subspecialty care. In particular, we ask that HRSA allow the averaging of clinical time over a longer period of time, such as a full year, and look forward to discussing additional approaches with you as you plan for future years.**

The loan repayment program guidance also requires that clinical service be conducted during "normally scheduled office hours," but it is unclear what this means in the context of subspecialty care provided in hospitals that need staffing 24/7. Certain subspecialists, including pediatric emergency medicine physicians, critical care pediatricians, and neonatologists, and others have normally scheduled work hours that include nights and weekends. **We urge HRSA to eliminate this requirement with respect to pediatric medical subspecialists and pediatric surgical specialists.**

In addition, care coordination is critical to providing high-quality pediatric care, particularly for children with medical complexity who have multiple chronic conditions that require the care of an array of providers. A core aspect of pediatric care coordination is the provider-family partnership that is critical for high-functioning care delivery to address the full spectrum of the child's needs. We appreciate HRSA's acknowledgement of care coordination functions in the program guidance, but **urge you to include the time that pediatric subspecialists spend providing those services to families in the allowable clinical service hours.**

Fellowship Clinical Service Hours

Section (b)(2)(A) of the statute specifically states that pediatric subspecialty fellows are eligible for the program "during … an accredited pediatric medical subspecialty, pediatric surgical specialty, or child and

adolescent mental health subspecialty residency or fellowship."[3] However, the service hours requirement means that virtually all pediatric subspecialty fellows will be ineligible for the program given fellowship research requirements. ACGME-accredited fellowships, for instance, require fellows to spend a significant amount of their time dedicated time to research activities.

There are important reasons for these research requirements. As stated previously, children are underrepresented in medical research. Fellowship research requirements help address this inequity. Requiring that research is part of every pediatric subspecialty fellowship ensures that those who will be taking care of children with serious, chronic or complex health care needs contribute to improving their care through research. Some fellowships have research rotations where fellows spend months at a time working solely on research. The requirement for performing 36 hours per week of clinical work for a minimum of 45 weeks per year while disallowing averaging over the course of a year or an entire fellowship is therefore totally incompatible with the operation of pediatric subspecialty fellowships.

We recommend that for current fellowship trainees, HRSA not require a specific number of clinical hours and instead only require that they are participating in a full-time accredited fellowship. The time fellows spend on clinical service and research is generally pre-determined by their training program and not something that the fellow has any control over. Requiring a specific number of clinical hours may arbitrarily exclude fellowships in certain subspecialties while including others. Barring this change, **we urge HRSA to adopt a significantly more flexible approach to assessing fellows' service hour requirements. That flexibility is needed to actualize the intent of Congress to include pediatric subspecialty fellows in the program.**

Recommendations for Service Hour Requirements

We strongly recommend that HRSA include *all* clinically relevant teaching and research in its definition of required service hours as it reviews this year's applications and moving forward. There are serious shortages of pediatric subspecialists in all parts of the country, and these shortages manifest themselves in access challenges everywhere. The most important thing HRSA can do to address these shortages is to invest broadly in the development of the pediatric subspecialty workforce and to recognize all of the important clinically relevant work that pediatric subspecialists do, including teaching and research, in addition to direct patient care. The existing clinical service hour requirement unfortunately does not reflect the full range of activities necessary both to care for children with serious, chronic or medically complex conditions and to support developing the future pediatric subspecialty care workforce.

In the event, HRSA chooses not to expand its service hour requirement to include teaching and research, we urge you to make the program as compatible with pediatric subspecialty training and practice as possible. Specifically, we urge HRSA to modify the physician clinical service hour requirements to:

- **Allow post-fellowship pediatric subspecialists to average clinical service time over the course of a year.**
- **Eliminate the requirement that clinical service happen during "normally scheduled office hours."**

[3] Section 775 of the Public Health Service Act [42 CFR 295f].

- **Eliminate the clinical hours requirement for those participating in a full-time accredited fellowship, or in the alternative, allow fellows to average clinical service time over their entire fellowship period (up to three years).**
- **Significantly increase allowances for important clinically-relevant work hours that are not involved in direct patient care, such as teaching, research, and quality improvement.**
- **Clarify that care coordination and consultation on specific patients is included in clinical service hours.**

ELIGIBLE SERVICE SITES

Recommendations for Eligible Service Sites

In order to make the program align with the statutory requirements for eligible service sites, we urge HRSA to:

- **Confirm that service sites are eligible if they *serve* a Health Professional Shortage Area or Medically Underserved Areas and clarify how they can demonstrate their eligibility.**
- **Accept Medically Underserved Populations (MUP) site attestations in the current application review process and make the MUP qualification process clearer in the next application cycle.**

The authorizing statute requires that anyone receiving loan repayment under the PSLRP must agree "to work in, or for a provider serving, a health professional shortage area or medically underserved area, or to serve a medically underserved population." Congress intentionally gave HRSA flexibility in determining eligible service sites because of differences between primary care and subspecialty care. Health professional shortage areas (HPSAs) and medically underserved areas (MUAs) are specific geographic areas determined largely on the basis of access to adult primary care services. HRSA does not have a shortage designation specific to pediatric subspecialty care, which makes flexibility very important in the implementation of this provision.

Pediatric subspecialty care is regionalized in nature and is most typically offered at large children's hospitals and other academic medical centers, which are often located in urban locations. Children's hospitals, unlike adult-focused medical facilities, are sometimes the only places in their state and region with the breadth of pediatric specialists and subspecialists, the pediatric-appropriate medical equipment, and other resources required to treat children, particularly those with rare and complex clinical conditions. Furthermore, teams of pediatric specialists are typically concentrated near large children's hospitals, underscoring the regional nature of pediatric specialty care for high-acuity conditions. As a result, it is not uncommon for children, particularly those with medical complexity, to travel out of their community, region or state to receive the extremely specialized care that can only be provided at a children's hospital.

Since children's hospitals employ a large number of pediatric specialty providers, as may other academic and large medical centers, the precise areas in which they are located are often not considered HPSAs or MUAs by virtue of their very location in that area. Yet, these institutions provide care to large catchment areas that include many underserved areas. In fact, on average, more than one-half of the children cared for at a children's hospital are covered by Medicaid and most of those children travel to the hospital from a low-income community. The current HPSA/MUA designations, which are limited in geographic

scope, do not adequately reflect the reach of children's hospitals and their staff into these underserved neighborhoods.

We appreciate that, this year, HRSA allowed flexibility in service site eligibility by allowing applicants and institutions to qualify by attesting to serving a medically underserved population (MUP), which can include people who are eligible for Medicaid, people who are low-income, people experiencing homelessness, Native Americans, and migrant farm workers. However, HRSA did not include a mechanism for applicants and institutions to demonstrate that they serve HPSAs or MUAs when not directly located in such an area. Instead, those sites were limited to attestations that they serve an MUP.

We note that the law states that eligible individuals must "agree[] to work in, or for **a provider serving**, a health professional shortage area or medically underserved area, or to serve a medically underserved population." The Program Guidance also includes language throughout referring to a site located in or serving a HPSA, MUA or MUP.[4] We also note that HRSA's guidance on this option was not very clear and resulted in a number of individuals and institutions believing that they were not eligible when they very well may have been based on MUP attestation.

We urge HRSA to ensure that no providers who are otherwise eligible for loan repayment are excluded from the program due to these site eligibility limitations. We look forward to working with you to refine the site eligibility processes and requirements to ensure they reflect the locations and patients served by children's hospitals and other locations where most pediatric subspecialists work.

ELIGIBLE SPECIALTIES

We urge HRSA to accept applications from all pediatric medical subspecialties and pediatric surgical specialties and to update its list of eligible subspecialties to include a number of missing subspecialties.

The HRSA website[5] contains a list of "approved pediatric medical subspecialists and pediatric surgical specialists,"[6] which includes child and adolescent psychiatry and 15 pediatric subspecialties: child abuse pediatrics, developmental-behavioral pediatrics, neonatal-perinatal medicine, pediatric cardiology, pediatric critical care medicine, pediatric emergency medicine, pediatric endocrinology, pediatric gastroenterology, pediatric hematology-oncology, pediatric hospital medicine, pediatric infectious diseases, pediatric nephrology, pediatric pulmonology, pediatric rheumatology, and pediatric transplant hepatology.

We appreciate that the website clarifies that eligible subspecialties "are not limited to" those included in the list since there are a number of pediatric medical subspecialties and pediatric surgical specialties not included. The program guidance specifies that physicians can be eligible if they have "received specialized training" or are "entering or receiving training" "in an accredited pediatric medical subspecialty or pediatric surgical specialty residency or fellowship."

---

[4] PSLRP Program Guidance. See, e.g. pages 3, 7, 8, 10, 11,20 23.

[5] HRSA. Apply to the Pediatric Specialty Loan Repayment Program. https://bhw.hrsa.gov/funding/apply-loan-repayment/pediatric-specialty-lrp.

[6] HRSA. Pediatric Specialty LRP Application and Program Guidance. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/funding/pediatric-specialty-lrp-application-guidance.pdf, page 8.

We are aware that there is confusion from subspecialty providers about whether those who have received specialized training in unlisted subspecialties are eligible for the program. We are aware of 17 additional pediatric medical subspecialties and pediatric surgical specialties that were not included in the list on the HRSA website as eligible subspecialties which we believe should be eligible. We note that no pediatric surgical specialties were included in the list, even though the program guidance and the statute make clear that pediatric surgical specialties are eligible. The missing specialties are: **pediatric addiction medicine, adolescent medicine, medical toxicology, pediatric hospice and palliative medicine, pediatric sleep medicine, pediatric sports medicine, pediatric anesthesiology, pediatric dermatology, pediatric otolaryngology, pediatric radiology, pediatric surgery, pediatric urology, child neurology, pediatric orthopedics, pediatric ophthalmology, pediatric neurological surgery, and pediatric plastic surgery**.

All but two of these 17 specialties have fellowships accredited by the Accreditation Council for Graduate Medical Education (ACGME).[7] Pediatric neurological surgery fellowships are accredited by the Accreditation Council for Pediatric Neurosurgery Fellowships.[8] Pediatric ophthalmology fellowships are certified compliant by the Association of University Professors of Ophthalmology.[9] Pediatric plastic surgery fellowships are ACGME accredited as "craniofacial surgery," a specialty that focuses on surgery on congenital anomalies.[10] In addition to ACGME accreditation, some pediatric orthopedic fellowships are accredited by the Pediatric Orthopaedic Society of North America.[11] **We strongly urge HRSA to include all of the above-mentioned medical subspecialties and surgical specialties in its list of eligible specialties.**

PRIORITY FOR SCHOOL-BASED PROVIDERS

While we understand that the law gives "priority" to PSLRP applicants in school-based settings, we believe that the only reasonable interpretation of this statutory provision is to treat a school-based service location as a positive factor for consideration rather than a strict preference. Because pediatric medical subspecialists, pediatric surgical specialists, and child and adolescent psychiatrists rarely work in school settings, the program guidance's strict preference given to applicants in school-based setting could make it very difficult for physicians to get funding through the program, especially with the limited resources available.

For most pediatric subspecialists who care for children from a wide geographic area and with the most serious illnesses, working in a school setting is simply incompatible with efficient and high-quality standards of care. We believe that the law, read in its entirety and given the legislative history, is inconsistent with HRSA's decision to create a tiering structure that puts school-based providers in a "Tier 1" status, which automatically puts any school-based applicants ahead of pediatric medical subspecialty and pediatric surgical specialty applicants. **We therefore strongly urge HRSA to consider school-based status as a positive factor for consideration and not a strict preference.**

---

[7] Accreditation Council for Graduate Medical Education. https://www.acgme.org/.
[8] Accreditation Council for Pediatric Neurosurgery. https://acpnf.org/.
[9] Association of University Professors of Ophthalmology Fellowship Compliance Committee. https://aupofcc.org/fellowship-programs-residentssubspecialties/pediatric-ophthalmology
[10] ACGME Plastic Surgery Subspecialties. https://www.acgme.org/specialties/plastic-surgery/overview/.
[11] Pediatric Orthopaedic Society of North America. https://posna.org/resources/fellowship-accreditation.

Thank you for considering these critical issues for the Pediatric Subspecialty Loan Repayment Program application process. As you work to develop the program for the next application cycle, we encourage you to not base this year's and future implementation on existing primary care platforms and to work with us to develop criteria that truly reflect the unique nature of pediatric specialty care. If you have any questions, please contact James Baumberger (jbaumberger@aap.org). We look forward to continuing to work with HRSA to improve child access to pediatric medical subspecialists and pediatric surgical specialists.

Sincerely,

Academic Pediatric Association
American Academy of Pediatrics
American Pediatric Society
Association of Medical School Pediatric Department Chairs
Association of Pediatric Program Directors
Children's Hospital Association
Council of Pediatric Subspecialties
Pediatric Policy Council
Society for Pediatric Research

CC: Luis Padilla, MD
Associate Administrator for Health Workforce

Israil Ali, MPA
Director, Division of National Health Service Corps